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The History in Patients with Urinary Incontinence

THERE IS LITTLE AGREEMENT among the experts on urinary incontinence. The only place where there is agreement is that most failures in the treatment of stress incontinence are not operative failures, but they are diagnostic failures. Of all the procedures used for evaluating urinary incontinence, the history is the easiest, one of the most important, and probably the most neglected. No special equipment is required, only time. It is necessary to ask all patients if they have urinary incontinence. Many little old ladies have had incontinence for years, but are embarrassed to mention it . . . or feel that it is women's lot in life and nothing can be done about it. Or possibly, they have talked to their next-door neighbor who was operated upon and is now worse. These operations have a bad name, despite the 95 to 100 percent cure rate quoted in the literature . . . The history is best taken by means of a form so that no questions are overlooked . . . When did your bladder difficulty start? (Patients with true stress incontinence practically always have a history of incontinence beginning with a pregnancy and becoming progressively worse with each pregnancy, only to improve following delivery. Incontinence returns, becoming severe at menopause.) What medications are you taking? (In our drug-oriented society, the list of medications that affect bladder function is growing at an astounding rate.) Do you have difficulty in starting your urinary stream? (This may represent an over-distended, thin-walled bladder or a urethral obstruction and the tense spastic patient may have these complaints, as it is impossible to urinate without relaxing the perineal muscles.) Do you notice dribbling of urine when you stand after urination? (This may represent a urethral stricture with a few drops of urine trapped behind it. It may represent a urethral diverticulum, but most commonly it is caused by a detrusor contraction secondary to an unstable or irritable bladder.) Do you feel that you completely empty your bladder? (If the patient says yes, this may or may not be true. But if the patient says no, she is invariably right.) Is urination painful after intercourse? (These patients usually have urethritis or possibly a urethral diverticulum. Most urinary tract infections in the female flare up secondary to intercourse.) Do you usually get up at night to urinate? (Nocturia two or more times indicates a small bladder capacity.) Does the sight, sound or feel of running water cause you to lose your urine? (Urinary incontinence associated with these sensations is typical of detrusor dysinertia.) Are you ever not aware that you are losing your urine? (Patients with detrusor dysinertia may have a continuous dribbling incontinence with no sensation of having to void.) Did you ever have to be catheterized because you were unable to urinate? (This is the experience of the patient with a partially decompensated bladder and overflow incontinence.) Do you find it necessary to wear some type of protection? (In my experience, incontinence of this degree is usually not stress incontinence. This may represent stress incontinence with superimposed urgency, or they have most likely some abnormality of bladder action.) While urinating, can you usually stop your stream? (The patient with true stress incontinence can do so. The patient with some abnormality of bladder action cannot. A detrusor contraction is set off and it cannot be stopped.) And finally, what do you think causes your bladder problem? (It is interesting that a number of patients say "Doctor, do you think it could be my nerves?" . . .)

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Extracted from *Audio-Digest Obstetrics and Gynecology*, Vol. 21, No. 3, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1930 Wilshire Blvd., Suite 700, Los Angeles, CA 90057.